

Health Care

Underfunding's effect on Canadian hospitals

MILAN KORCOK

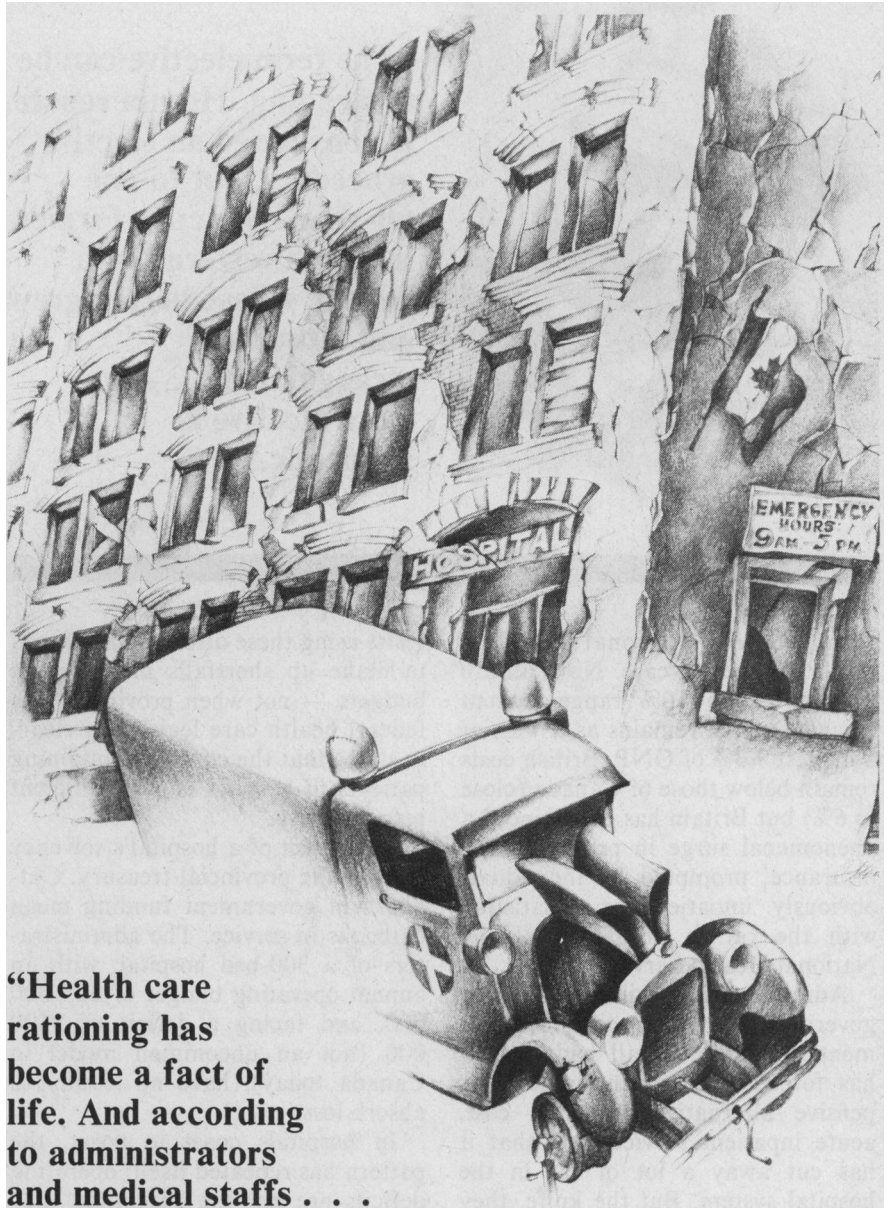
Earlier this year the Canadian Medical Association commissioned medical writer Milan Korcok to travel across Canada to examine the consequences of underfunding on the Canadian health care system. After he had filed his official report with CMA we asked Mr. Korcok for a wrap up of the major findings of his 3-month investigation. Here is the first of two reports:

A growing number of Canadian hospitals, unable to make ends meet on the parsimonious budgets parcelled out by their provincial treasuries, have been forced to close beds, cut back surgical schedules, encourage staff attrition, and table requests for equipment purchase or replacement.

As a result, patients are waiting longer than ever to get into hospital, elective services in many institutions are being dramatically curtailed or totally eliminated, and medical staffs are forced to concentrate their dwindling resources on the needs of emergency or urgent cases.

Health care rationing has become a fact of life. And according to administrators and medical staffs interviewed in the course of a recent CMA-sponsored investigation of hospital funding, rationing will continue until governments either increase their contributions to health services or reverse the political imperatives that preclude alternative sources of funding.

Hospital administrators feel under a state of siege: restricted to funding levels that haven't changed perceptibly in 10 years in terms of real wealth, yet expected to deliver "the best" of a medical technology of which costs have soared out of sight. Administrators chafe at charges, often by legislators, that hospital costs have been allowed to run wild and, if unchecked, will bring



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the entire Canadian economy to ruin. They can show that Canada's spending on health care has remained remarkably consistent at a time when most other comparable countries have sharply increased theirs.

In 1970, France, the United States, Sweden, West Germany, the Netherlands and Canada, were all spending in the range of 6% to 7% of

pull them out of a fiscal hole. There are hospitals with access to cash reserves via preferred room rates, revenues from parking garages, gift shop sales and hospital auxiliaries and foundations. But this money is generally used only for a few, limited capital items such as a fetal monitor, or a new camera or a few additional parking spaces. Hospitals

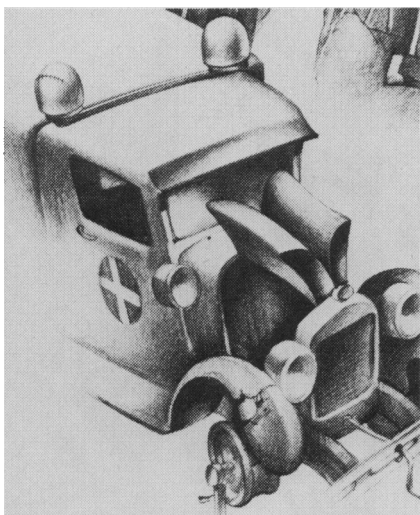
commitment to reducing transfer payments for health care might squeeze the hospitals even more and force them to face up to their own deficits, without provincial help: by borrowing at the banks, using up their meager discretionary funds, or taking it out of next year's budget.

The Royal Columbian Hospital, in New Westminster, BC, already knows how painful this contraction of services can be. The Royal Columbian has a high emergency patient load, lots of intensive care, a large trauma service. It is a high cost-per-patient-day institution. Operating costs for 1981-82 were close to \$57 million, the health ministry approved only \$51 million. Protracted negotiations left the Royal Columbian with a total of \$1.5 million to make up from last fiscal year, and a commitment to slice \$4 million out of its current operating budget proposal for 1982-83.

The only way to make up something like \$6 million is to cut back a lot of services; there is no choice. Administration and the medical staff had, by June, closed 109 of the hospital's 500 beds, they closed half of the six operating rooms, and moved even closer to emergency-only status. This can only aggravate existing problems since the Royal Columbian had already cut services dramatically even before the most recent budget confrontation. According to medical staff, most admissions were already coming in through emergency, there had not been an elective medical patient admitted in 3 to 4 years, and the average waiting time had continued to escalate, so that a patient requiring, say, orthopedic surgery, better be prepared to wait at least 4 months.

As acute as the fiscal squeeze may be in New Westminster, the Royal Columbian is not a rarity among Canadian hospitals.

• At the Moncton Hospital in New Brunswick, rated at 537 beds, approximately 30 beds are usually kept closed to save costs, despite the fact that as of February this year there was a surgical wait list of approximately 1400 patients (only half of these for day surgery). General practice, neurosurgery, and medicine routinely went over their bed allotments and "borrowed"



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their Gross National Product (GNP) on health care. Now, all are in the 8% to 10% range, except Canada, which remains as it was, at a modest 7.3% of GNP. British costs remain below those of Canada (close to 6%) but Britain has experienced a phenomenal surge in private health insurance, prompted by individuals obviously impatient or unsatisfied with the rather slow plod of the National Health Service.

Administrators will admit that government-imposed cost containment has not been all bad, that it has forced development of less expensive alternatives to high cost, acute inpatient service, and that it has cut away a lot of fat in the hospital system. But the knife, they say, is now cutting away at the bone, and is endangering the very patient it was designed to help.

Whether hospitals function on a global budget or line by line approval, what they get each year is determined by health ministries and treasury departments. Few hospitals can count on community philanthropy to

resist using these discretionary funds to make up shortfalls in operating budgets — not when provincial and federal health care legislation clearly states that the cost of maintaining patients in hospital is a government responsibility.

The secret of a hospital's solvency rests in the provincial treasury. Cutbacks in government funding mean cutbacks in service. The administrators of a 300-bed hospital, with an annual operating budget of \$25 000 000, and facing a deficit of \$600 000 (not an uncommon model in Canada today), have no leeway to absorb loss.

In hospitals coast to coast, the pattern has repeated itself; operating deficits are not the exception, they are the rule. And though provincial governments have tended to pick up deficits of their member hospitals after all the squabbling was done, the largess can no longer be considered automatic. In most provinces visited in the course of the CMA investigation, there was an apparent fear that the federal government's

from other services — usually surgical elective beds serving as “lenders”. As a result, an elective gynecological procedure at Moncton Hospital could involve a wait of 15 to 16 weeks.

- At St. Paul's Hospital in Saskatoon, government's decision to fund only 282 of the institution's 339 beds has contributed to what hospital administration describes as “a relentless course to bankruptcy”. Unable to build up significant capital reserves because of government regulations, and saddled with a reimbursement system based on total patient days and not on the much higher costs actually expended on its patients, St. Paul's has accumulated over \$1 million in deficits over the past 5 years, and finds itself overdrawn at the bank an average of once a month. St. Paul's has not had one new or expanded program request approved in 5 years, it has eliminated all staff travel, all seminars, all education, and has delayed hiring any new staff.

- At the 650-bed Oshawa General Hospital, 64 km east of Toronto, administration has a reputation for running a tight ship. Executive Director David Home is often invited to lecture other hospital administrators on cost effectiveness and operations. When interviewed by CMA, Home and his staff were struggling with a \$1.25 million deficit, despite all their cost cutting methods and despite having taken out as many as 80 beds at one point. A 40-bed unit is routinely taken out of service during the summer as a cost saving measure, but when administration tried to take out a second 40-bed unit in an attempt to save costs, the roof fell in.

“It was a nightmare”, said Home. “It was unmanageable. Really sick people” were forced to lie on hall beds in the emergency department for up to 36 hours, he said.

Each year it just gets tougher and tougher to close beds. The Oshawa area is like many other “boom town” communities in Canada. It has grown from 70 000 people to more than 120 000 in 15 years, yet there are now 30 fewer active hospital beds.

- At Edmonton's 938-bed Royal Alexandra Hospital, Director of Admitting Services Betty Higgins told

the CMA that it has become customary to close approximately 100 beds during the summer. Last summer, up to 117 beds were shut down at one time. On the day that Ms. Higgins was interviewed, there were 2807 people on the hospital waiting list, almost one quarter of these having been on the list for at least 6 months.

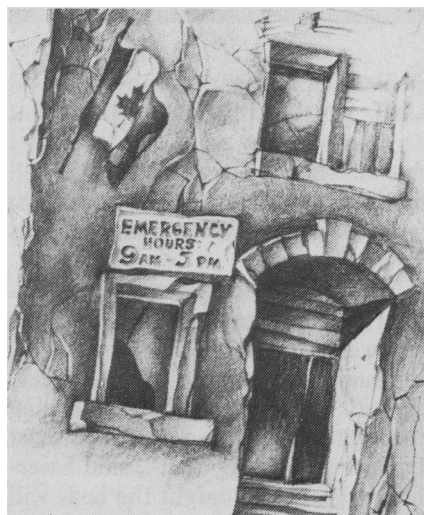
In the meantime, Assistant Executive Director of Administration Harold Porter, who sees nothing but budget tightening out of the provincial treasury (no new programs, no expansion) is borrowing \$4 million at the bank just to pay the bills and pay the salaries. When faced with the need to chop large costs, administrators look first to ward units. As wards are closed down, staff can be cut, hiring can be frozen, “vacations” can be imposed. Staff costs account for at least 70% of a hospital's operating budget.

Many bureaucrats tend to say that bed closures are not always necessitated by government-imposed cost reductions, that shortage of

dra believe money has everything to do with it, that if nurses could concentrate on acute care nursing instead of shuffling heavy beds back and forth in search of space or instead of tending to elderly and chronic patients who have no place else to go, they would stay in the profession. Similarly, if additional shifts were added so nurses could lead more predictable and normal lives, they would stay. But all of these things cost money, and because the money isn't there, the nurses stay away, and work instead in supermarkets and department stores.

This is not a situation unique to Alberta, it's prevalent in most provinces. When hospital wards are closed down the ripples continue on forever. Because there are no available nursing beds, patients may be kept in recovery rooms longer, or they may have to spend a night or two in emergency department observation units. This blockage in the wards can back up and put pressure on the emergency department, on

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nursing staff is a big problem.

Alberta provides a good example of this dichotomous rationalization for nursing shortage. That province now has 3000 fully trained nurses working outside of their profession. Why don't they go to work in hospitals? Has money nothing to do with their withdrawal from nursing? Medical staff at the Royal Alexan-

CCU/ICU, on the operating rooms. The result is that surgeons are prevented from scheduling patients for surgery because there is no place to put them after. And so these patients are either cancelled out of surgery at the last minute, or not even booked in the first place.

At the Halifax Infirmary, the shift day in most of the nine operat-

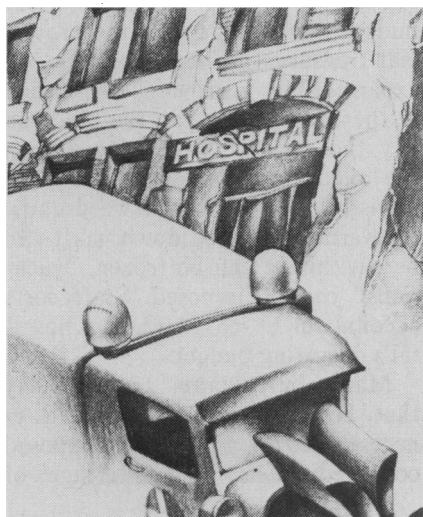
ing rooms runs from 7:30 am to 3:30 pm. One of the rooms runs to 5 pm, another to 7 pm.

Once the normal 3:30 pm nursing shift goes off duty, there is no one to replace it. All these rooms must close because overtime for nurses is frowned upon. Yet cancellations for all operating room services continued to be common. Dr. Oliver H.

"probably the biggest we've had".

Defenders of budgetary restraints will say that Winnipeg's Health Sciences Centre is now in the middle of a building phase and relief is on the way. But as Swerhone noted, he first signed on at the hospital more than 20 years ago with a mandate to carry through the development of a new centre. He expects its first

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Millard, president of the medical staff at the Infirmary, says that anyone who has an ailment which is not disabling but which may still interfere with his work, will have to wait between 6 weeks and 6 months for admission.

The day Peter Swerhone, president of Winnipeg's Health Sciences Centre, was interviewed was not an unusual day: middle of the week, typical midwinter freeze slicing through the city, no epidemic, just business as usual. "But", said Swerhone, "by 6 pm tonight the beds will all be full." The night before, the hospital had one medical bed, two surgical beds, and two private beds available — in a hospital with 1270 beds.

One of the consequences of this overcrowding is that there have been up to 20 cancellations per day in elective surgery, all of them booked patients. Despite the cancellations, and the wait lists and the inevitable cutbacks, the Health Sciences Centre was at that point facing a deficit of between \$4 and \$5 million,

phase to be on stream just about the time he celebrates his 25th anniversary with the hospital.

Across town, at the St. Boniface General Hospital, overcrowding has also affected virtually all departments, causing backups in surgery, ICU/CCU, operating rooms, day surgery, even the observation unit — in which some patients have spent several days before a regular inpatient bed could be found for them.

Dr. Jack Rusen, then director of the emergency department, has reported that approximately 130 seriously ill patients — many with chest pains or confirmed heart attacks — must be transferred annually to other hospitals due to lack of space. There would be many more transfers if other hospitals didn't also have bed shortages.

Dr. Diamond Kassum, director of intensive care surgery at St. Boniface, noted that the waiting list for ICU at the time of the Winnipeg interviews in February had about 100 people, most of them cardiac

patients and many forced to wait 6 to 8 weeks for admission. Surgical cancellations among these patients were running at about two a week.

Within this context there have been misadventures. Last September a man with an aortic aneurysm whose surgery was cancelled for lack of ICU space was sent home. His aneurysm ruptured a couple of days later. He was brought back to the hospital and he died. An inquiry showed that there was no fault involved, but, as Dr. Kassum noted, under normal conditions such a patient would not have been sent home.

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Harvey Fox, executive director of the South Saskatchewan Hospital Centre in Regina (which incorporates the Plains and the Pasqua hospitals), says there is a very clear attempt to ration such procedures as cardiac surgery. In 1980 a city wide cardiac science review done by experts from out of the area recommended an expansion of cardiac surgery, cardiac labs and catheterization services. The open heart surgery would be centralized at the Plains, catheterization at the Pasqua. The report said that South Saskatchewan, with an estimated population of 500 000, should certainly be allowed between 200 to 250 open heart surgical procedures and between 500 to 600 cardiac catheterizations per year. So far, the province has approved funding for only three open heart cases per week, while in fact six patients per week are being referred into the program. Obviously, waiting lists in this program are growing fast.

When Fox was interviewed last winter, he reported that up to that point there were 45 patients on the open heart list who were considered "urgent", yet some of these would have to wait 6 months for their surgery.

As waiting lists grow, the delineation between emergent, urgent, and

elective, blurs. Patients don't fit neatly into such categories. One patient, booked July 1981 for disc surgery at the Royal Alexandra in Edmonton, was not done until the middle of November. He not only endured 6 months of intense pain, but was unable to work for 6 months. Another woman with a disc problem was forced to wait nearly 2 years for her surgery at the Royal Alexandra.

In another documented case, a dying patient with a metastatic carcinoma was sent home from the emergency department because of a bed shortage. He was in such pain that he committed suicide at home. It could be argued that a stay in hospital would not have changed this patient's ultimate prognosis, but more and more physicians are becoming concerned that quality of life is being sacrificed to the reality of waiting lists.

Waiting lists are intended to put "elective" on hold. (Although there is now plenty of evidence that not only elective but many urgent patients are being put on hold. On Jan. 31, 1982, for example, the waiting list at St. Paul's hospital in Saskatoon had 1340 patients. Of these, 104 were "urgent" and nearly 100 were children with serious hearing difficulties — difficulties which could seriously affect their speech and their schooling if left unattended. Their wait time was 3 to 4 months.)

The term elective can be misleading. Hernia repair is considered an elective procedure, but to one 60-year-old active farmer in Southwestern Nova Scotia, whose hernia grew and ultimately strangulated (all for lack of a surgical bed at Yarmouth's Western Regional Medical Centre) the word elective is academic. The fact remains that though his life was saved through emergency treatment, he couldn't work while waiting for the repair and he lost farm income.

It doesn't seem as if the provincial treasury gained a lot by keeping that income earner and tax generator on "hold". But it isn't the treasurer who finds himself under the gun. It's the physician who must decide which patient gets a bed, or surgery, or into the ICU, and which one will be put on "hold". It's an awesome

responsibility, one that increasing numbers of Canadian physicians are now being faced with.

The chief of medicine at the Western Regional Medical Centre in Yarmouth, Nova Scotia, Dr. Raj Parkash, says that the lack of beds and the pressure to get patients discharged forces many physicians to practise a form of medicine they can't be comfortable with. Because there are many evenings at the medical centre when there may be 12 to 14 patients on stretchers in corridors outside the outpatient/emergency department, and many of these must wait overnight to get beds, Parkash has to make compromises. Patients who would ordinarily be admitted for symptoms such as chest pain often cannot be admitted.

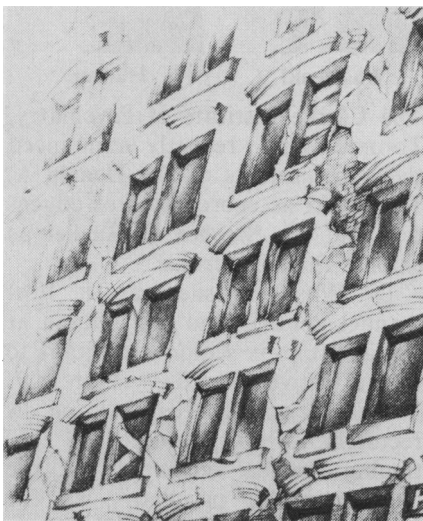
Dr. Parkash now spends many hours with patients in the outpatient department — often leaving them there for 24 hours — trying to rule out the possibility of heart attack before sending them home. Most physicians would say that a patient who has had chest pains two or

"just can't be sure about".

Dr. Paul Landrigan, past president of the medical staff at the Halifax Infirmary shares the view that too much pressure is put on physicians to clear beds earlier than their professional judgement allows. "There are just too many close calls", he says.

"You're calling it pretty close when you discharge a lung resection for an adenoma on the eleventh day", says Dr. Landrigan, describing the plight of a 28-year-old woman from Truro whose incision opened after she was discharged from the Infirmary. She went to hospital in Truro to have the incision closed and about 1 week later she had a massive hemorrhage and died. If she would have stayed at the Infirmary for at least a couple of more days, the outcome might have been different, says Landrigan.

The pressures are intensifying. And they are leaving their mark on Canadian medicine. Dr. D. Brian O'Brien, vice president of the medical staff at the Halifax Infirmary



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three times within 24 hours should be admitted and kept under observation. But lately, says Parkash, "I have been forced to keep that type of patient in outpatient for 24 hours and tell him to call me if his pain comes back."

Every month, there are five or six patients sent home under such conditions about whom Dr. Parkash

says out loud what more and more Canadian doctors are just beginning to feel and to fear: "In an effort to live with our burden, we're discharging patients earlier and earlier for each surgical procedure, with more and more risk to the patient, and a hell of a lot more medical and legal risk, and with more stress on surgeons."■